

**Testimony Opposing
H.B. No. 6846: An Act Implementing the Governor's
Budget Recommendations for Human Services Programs**

Sharon D. Langer, M.Ed., J.D.

Human Services Committee

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Senator Moore, Representative Abercrombie, and members of the Human Services Committee:

I am the Advocacy Director at Connecticut Voices for Children, a research-based public education and advocacy organization that works statewide to promote the well-being of Connecticut's children, youth, and families.

I am testifying today on behalf of Voices for Children about the provisions in the bill that drastically change the HUSKY (Medicaid and the Children's Health Insurance Program) as they relate to children, parents, and pregnant women. We believe that these proposed changes are in part illegal, ill advised, will hurt children and families, and will in the long run cost the health system and the state more money.

Connecticut Voices opposes the proposal to eliminate HUSKY coverage for 34,000 parents and pregnant women with income above 133% of the federal poverty level (FPL).¹ Parents are currently eligible between 133% and 196% FPL (\$26,720 to \$32,253 for a family of three) and pregnant women are currently eligible up to 258% (\$51,832 for a family of three; pregnant woman counts as two people).² The Governor assumes without any way to know for certain that these families will purchase commercial coverage through the state's health insurance marketplace, Access Health CT (herein AHCT). We therefore urge the Committee to reject the changes made to Sections 3 and 5 of the bill. Our opposition is predicated on research and experience in our own state, as well as the experience of other states - in particular Rhode Island - which rolled back its eligibility for parents last year.

Pregnant Women on HUSKY

Roll-back of pregnant women coverage violates federal law. In addition, loss of Medicaid coverage for pregnant women holds special risks for women *and their babies*. Connecticut may not roll back its income limit for pregnant women to 133% FPL. The Affordable Care Act requires states to maintain a minimum income level that it had in place in 1989 if that standard was higher than 133% FPL.³ Indeed, Connecticut's income limit for pregnant women at that time was 185% FPL.⁴

We oppose rolling back the income limit to 185% FPL. Connecticut raised the income limit for pregnant women to 250% FPL in 2008 (under ACA income counting rules the limit is now 258% FPL) to more closely approximate the income limit for children in the subsidized portion of HUSKY (300% FPL, now 318% FPL under the ACA income counting rules). Only three states cover pregnant women with income cut-off as low as 138% FPL⁵ (ID, OK and SD). Twenty-six states cover pregnant women over 200% FPL and five over 250% FPL. Connecticut should follow the majority of states and maintain its current eligibility for pregnant women at 258% FPL.

Ensuring that pregnant women get the care they need during and after pregnancy is essential to women's health and the delivery of a healthy newborn. Ensuring that newborns receive check-ups and immunizations during the first year of life is also vital to the development of young children. Medicaid provides for one year of *automatic* coverage for newborns so long as the baby is born to a woman already on Medicaid without requiring a new application to enroll the baby.⁶ Rolling back eligibility for pregnant women means far fewer babies on HUSKY A will have such automatic coverage and more new mothers will have to sign up their babies for coverage. Given the current challenges facing the Department of Social Services in processing HUSKY applications (even after they have been submitted through Access Health CT), this is no time to take away automatic newborn coverage from babies. **In other words, eliminating coverage for pregnant women will deprive not just mothers of health insurance coverage, but newborn babies as well.**

Pregnancy is not a qualifying event to enroll in commercial coverage through Access Health CT. Generally, uninsured individuals have an opportunity to enroll in commercial plans through AHCT only during an open-enrollment period. The 2015 open-enrollment period, for example, ended on February 15 of this month. The Affordable Care Act specifies life events, such as loss of coverage (including loss of Medicaid), that entitle a person to a special enrollment period.

Pregnancy is not a qualifying event for a special enrollment period.⁷ If Connecticut were to reduce the income limit for pregnant women on Medicaid such women would qualify for a special enrollment period due to loss of insurance coverage (assuming they could afford the premiums and other out-of-pocket costs of the marketplace plans). However, other uninsured women who later became pregnant would not be able to enroll in commercial coverage offered by AHCT based on pregnancy alone. This is yet another important reason to maintain coverage for pregnant women in HUSKY.

Parents on HUSKY

Many HUSKY parents are likely to become uninsured or lose meaningful access to care. Our state has been a standout in fulfilling the overarching goal of the Affordable Care Act to increase the number of individuals and families with insurance coverage and access to needed health care. This has been accomplished through a variety of approaches employed well *before* January 1, 2014 when new coverage options became available. In 2007, Connecticut aligned eligibility for parents and children in HUSKY and in 2008 the state increased coverage for pregnant women. We have long offered subsidized coverage to children up to 300% FPL. All of these improvements have contributed to Connecticut having one of the lowest uninsured rates in the nation – even before we expanded Medicaid coverage to low-income adults (HUSKY D) and provided access to other insurance plans through AHCT on January 1st of last year. The Governor's recommendations runs counter to the purpose of the Act to extend affordable insurance coverage for low-income parents and pregnant women. It creates an unnecessary risk that many of them will join the ranks of the uninsured. Research from other states and data from AHCT demonstrate that **even with subsidies many of these parents will forgo coverage and/or needed care due to unaffordable costs of the marketplace plans.**

Several states in recent years have rolled back their eligibility for parents on Medicaid. **Not only did parents lose health insurance coverage but thousands of children in these states also lost coverage, notwithstanding that they remained eligible.** Rhode Island may be the most instructive for Connecticut because it reduced the income limit for parents from 175% FPL to 138% FPL when the new health plan coverage options became available in 2014 under the

Affordable Care Act. As of May 2014 (the most recent data available), 43% of the parents remained eligible for Medicaid (when their eligibility was reviewed in January 2014) and only 11% enrolled in and paid premiums for health plans offered through the marketplace. The remaining 29% are assumed to be uninsured.⁸

In 2013, Governor Malloy similarly proposed to roll-back parent eligibility in HUSKY to 133% FPL in anticipation of health plan coverage offered through the new marketplace beginning in 2014. At that time researchers from the University of Massachusetts Medical School provided a conservative estimate of the number of parents who would likely become uninsured – even with the availability of federal subsidies to help purchase coverage. Of the then estimated 37,500 parents who would be affected, as many as 11,000 (29%) were expected to forgo purchasing coverage through Access Health CT.⁹ There is no reason to believe that this will not be the case two years later.

That is because even with federal subsidies to help pay premiums and lower other out-of-pocket costs, such as deductibles and co-pays, families between 133% FPL and 200% FPL are expected to pay 3.02% to 6.34% for premiums alone.¹⁰ These costs are too high for struggling low-income families and may mean that families that pay the premiums for coverage will still forgo care. Low-income families might even avoid free preventive care due to the risk that it could lead to costly non-preventive services. Several studies show that even nominal cost-sharing, such as a \$2.00 copay for prescription drugs imposed on Medicaid beneficiaries in Utah¹¹, caused low-income individuals to forgo medically necessary care, resulting in adverse outcomes and increased emergency room use.¹² Copayments are particularly harmful to vulnerable individuals with chronic conditions such as diabetes or mental illness whose need for multiple medications and more frequent care can make even nominal costs prohibitive.

We also have evidence in Connecticut that we can expect far fewer individuals to enroll in subsidized private health plans through AHCT. In 2011, data provided to the Connecticut's Health Insurance Exchange Board indicated that there were approximately 65,000 uninsured individuals with income between 139% FPL and 200% FPL.¹³ Recent data from Access Health CT reported to the Connecticut General Assembly indicates that only about 18,000 individuals in this income range (27%) had signed up in 2014.¹⁴

HUSKY coverage is tailored to the needs of low-income families. Currently, HUSKY A parents pay no premiums or other out-of-pocket costs, and have access to medically necessary transportation, dental and behavioral health, and substance abuse services, as well as prescriptions without co-pays. In contrast,

- transportation to medical appointments is not a covered service provided by a marketplace plan;
- dental coverage is available through the marketplace for adults, but at an additional and unsubsidized cost; and
- access to behavioral health services is limited or too expensive under many commercial plans. There is tremendous concern that individuals whose mental health conditions are controlled with psychiatric medications will forgo those drugs if they have to pay even nominal amounts.

It is very likely that many of these parents, struggling to pay rent, utilities, food, clothing, and other essential items for their children, will forgo paying for their own health insurance coverage, rather than skimp on supports for the family as a whole.

Children on HUSKY may lose coverage or access to care if their parents lose coverage.

Children on HUSKY with family income up to 196% of the federal poverty level remain eligible for HUSKY A until 2019 under the Affordable Care Act. We are, however, very concerned about the effects of the parent's loss of coverage on their children's access to coverage and care.

A recent example of how rolling back parent coverage affects children is from the State of Maine. In 2012, Maine reduced parent eligibility for MaineCare from 200% FPL to 100% FPL, although children below 200% FPL remained eligible. More than 28,500 parents lost Medicaid coverage. **Thirteen percent of children on Maine's CHIP program (MaineCare) lost coverage when their parents lost eligibility.**¹⁵

Research demonstrates that when whole families are covered together the number of children who are insured and have access to care is much higher.¹⁶ Insured children with uninsured parents are nearly 2.5 times more likely to experience an insurance coverage gap than insured children with insured parents.¹⁷ Insured children with uninsured parents are at greater risk of having unmet health care needs and having never received at least one preventive counseling service.¹⁸ A child with publicly insured parents is about 8 times more likely to be enrolled in public coverage compared to a child whose parent is uninsured.¹⁹ Moreover, whether children get health care is related to parental use of health care, and – not surprisingly but significantly – “the health of parents can play an important role in the well-being of their children.”²⁰

Connecticut can be proud of the progress it has made in reducing the number of uninsured children over the last 17 years – due in no small measure to the success of the HUSKY program. This is no time to risk increasing the number of uninsured children and parents.

Other Cuts to the HUSKY Program

We also oppose the following health funding reductions proposed by the Governor. Such reductions may not require a statutory change to implement, but would negatively impact the HUSKY program for children, parents and pregnant women.

- 1. Elimination of funding for community-based Healthy Start programs.** Healthy Start assists pregnant women in accessing health coverage and prenatal care.
- 2. Reduction in HUSKY provider rates.** It is unclear from the budget language which providers will see a rate decrease. The Governor proposes giving the Department of Social Services discretion as to how to implement such proposed changes. Providers are not required to participate in Medicaid and reducing rates will only exacerbate a shortage of providers, particularly specialists. We are therefore concerned that such reductions if adopted will make it even harder for HUSKY members to find a doctor or other health care provider to treat them.
- 3. Elimination of funding for independent performance monitoring in the HUSKY Program** (\$208,050 per year, (though 50% of this cost should be reimbursed by the federal government). Independent performance monitoring has been state-funded since 1995 and is conducted by Connecticut Voices for Children under a contract between DSS and the Hartford Foundation for Public Giving. This project provides information on enrollment patterns, long-term trends in the use

of children's health services, including well-child, dental, emergency, and asthma care.²¹ This information is *not* reported by the Department's administrative services organization ("ASO") contractor. The project also provides data on maternal health and birth outcomes in the HUSKY Program, including low birth-weight, preterm births, prenatal care, births to teen mothers, and smoking among mothers. This research is based on linked birth-HUSKY enrollment data that is *not* available to the Department's ASO contractor. Both Departments of Social Services and Public Health utilize the data and analyses conducted under the HUSKY performance monitoring project to improve administration of the program.

Thank you for this opportunity to testify regarding H.B. 6846. Please feel free to contact me if you have questions or need additional information. I can be reached at slanger@ctvoices.org or (203) 498-4240 (x 121).

¹ Statement of Secretary Benjamin Barnes, Connecticut Office of Policy and Management at a press conference after release of the biennium budget (February 18, 2015).

² Under the ACA there is an automatic disregard of five percent of income. As a result, the federal poverty level thresholds are often referred to as 138% FPL and 201% FPL, rather than 133% FPL and 196% FPL, respectively. The 2015 federal poverty guidelines are available at <http://aspe.hhs.gov/poverty/15poverty.cfm#guidelines>, and will be applied to HUSKY in March 2015.

³ 42 C.F.R. § 435.116 Pregnant women.

(a) *Basis*. This section implements sections 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV), and (IX); and 1931(b) and (d) of the Act.

(b) *Scope*. The agency must provide Medicaid to pregnant women whose household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section.

(c) *Income standard*. The agency must establish in its State plan the income standard as follows:

(1) The minimum income standard is the higher of:

(i) 133 percent FPL for the applicable family size; or

(ii) Such higher income standard up to 185 percent FPL, if any, as the State had established as of December 19, 1989 for determining eligibility for pregnant women, or, as of July 1, 1989, had authorizing legislation to do so.

⁴ P.A. 88-217, An Act Concerning Medical Assistance Provided by The Department of Income Maintenance.

Sec. 1. (NEW) The commissioner of income maintenance shall provide, in accordance with federal law and regulations, medical assistance under chapter 302 of the general statutes to needy pregnant women and children up to one year of age whose families have an income up to one hundred eighty-five per cent of the federal poverty level.

Sec. 2. *This act shall take effect January 1, 1989.* (emphasis supplied).

⁵ See fn. 2 for an explanation of the reference to 138% FPL v. 133% FPL.

⁶ See, <http://www.medicaid.gov/medicaid-chip-program-information/by-population/pregnant-women/pregnant-women.html>; See also, Centers for Medicare & Medicaid, State Health Official Letter #09-009 (CHIPRA #5), Retrieved from <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO083109b.pdf>

⁷ The list of qualifying events, including having a baby and loss of insurance, is available at <https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/>

⁸ Communication with Robert Seifert, MPA, University of Massachusetts Medical School (February 13, 2015).

⁹ London, K., Seifert R., Gershon, R., *Consequences of Proposed Eligibility Reduction of HUSKY A Parents*, University of Massachusetts Medical School, Center for Health Law and Economics, Connecticut Health Foundation (March 2013), Retrieved from <http://www.cthealth.org/wp-content/uploads/2013/03/Consequences-of-Proposed-Eligibility-Reduction-of-HUSKY-A-Parents.pdf>

¹⁰ Kaiser Family Foundation, <http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/>

¹¹ Ku, L., Deschamps, E., and Hilman, J., "The Effects of Copayments in the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program," Center on Budget and Policy Priorities, November 24, 2004, Retrieved from <http://www.cbpp.org/files/11-2-04health.pdf>

¹² Ku, L., and Wachino, V., *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings*, Center on Budget and Policy Priorities, July 7, 2005, Retrieved at <http://www.cbpp.org/files/5-31/05health2.pdf>

¹³ Mercer Presentation to Connecticut Health Insurance Exchange Board meeting (December 15, 2011), Retrieved from http://www.ct.gov/hix/lib/hix/CT_HIE_Board_Presentation_-_12-1-2011_Final.pdf

¹⁴ Access Health CT Quarterly Report to the Connecticut General Assembly Human Services Committee (January 29, 2015).

¹⁵ Maine Children's Alliance. *Ensuring health coverage for Maine families with children in 2014: A health policy brief by the Maine Children's Alliance*. Retrieved from http://www.mekids.org/assets/files/issue_papers/healthcoverage_children_2014.pdf

¹⁶ Dubay, L, and Kenney, G, "Expanding public health insurance to parents: effects on children's coverage under Medicaid," *Health Serv Res* 38(5): 1283-1301 (2003).

¹⁷ DeVoe, JE, Tillotson, CJ, and Wallace, LS. "Children's Receipt of Health Care Services and Family Health Insurance Patterns," *Ann Fam Med* 7(5): 406-413 (2009).

¹⁸ *Id.*

¹⁹ GAO, *Given the Association between Parent and Child Insurance Status, New Expansions May Benefit Families*, GAO-11-264, February 4, 2011, Retrieved from <http://www.gao.gov/products/GAO-11-264>

²⁰ Committee on the Consequences of Uninsurance, Institute of Medicine, *Health Insurance Is a Family Matter*, Washington, DC: National Academy Press, 2002

²¹ See for example, Lee, MA, *Fewer Children Experience Gaps or Loss of Coverage in the HUSKY Program*, (January 2014) Retrieved from <http://www.ctvoices.org/sites/default/files/h14huskycoveragegaps20102012.pdf>; Lee, MA, and Feder, K, *Dental Services for Children and Parents and Parents in the HUSKY Program in 2012: Utilization Is Improved Over 2008 but Unchanged from 2011* (August 2014), Retrieved from <http://www.ctvoices.org/sites/default/files/h14dentalcare2012.pdf>